Printed: 09/12/2013 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	17E242			B. WING			09/12/2013	
	OVIDER OR SUPPLIER		STREET ADDRE		TE, ZIP CODE			
COMMUN	ITY HOSPITAL ONAG	A LTCU	206 GRAI ST MARY	ND AVE 'S, KS 665	36			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS			F 000				
	The following citations represent the findings of a Health Resurvey.							
	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)			F 157				
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).							
	The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.							
	The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.		ent's					
LADODATON	The facility had a cen	not met as evidenced to sus of 33 residents. The R/SUPPLIER REPRESENTATIV	e		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE				(X3) DATE SURVEY COMPLETED	
	17E242			B. WING		09/1	2/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
	ITY HOSPITAL ONAG	A I TCU		AND AVE	,		
				RYS, KS 665	336		
040.15	) ID SUMMARY STATEMENT OF DEFICIENCIES			-		PODDECTION	(X5)
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F 157	Continued From page	e 1		F 157			
	sample included 14 residents. Based on observation, record review and interview, the facility failed to notify the physician for 1 of 14 sampled residents, who had a change in his/her status. (#38)						
	Findings included:						
	- Resident #38's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 5/15/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 13, which indicated intact cognition. The MDS indicated the resident was independent with bed mobility, transfers, walking, locomotion and eating, and his/her balance was not steady.						
	The 5/16/13 care plar independent with tran	n indicated the resident asfers.	was				
	The 5/23/13 at 5:50 PM, nurse's notes revealed the resident came in from the patio, sat down to eat and when the staff gave the resident his/her medications, his/her skin was very pale, cool and clammy and his/her lips were white in color. Staff transferred the resident to his/her room, he/she was able to stand to transfer from the wheelchair to the bed, and the resident's vitals signs were: temperature 97.6, pulse 58, respirations 20, blood pressure 63/41, and oxygen saturation 97% on room air.		n to /her I and Staff she chair re: blood				
	The 5/23/13 at 6:20 PM, nurse's notes revealed the resident's vital signs were: blood pressure 86/35, pulse 70, oxygen saturation 95%, the resident's skin was cool and not as clammy, he/she was alert and still able to transfer, without difficulty, to the bed.						
	The 5/23/13 at 7:15 F	PM, nurse's notes revea	iled				

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
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F 157	Continued From pag	ie 2		F 157		
. 10.	the resident's vital signs were: blood pressure 120/63 and pulse 68 and the resident was resting quietly.			. 16.		
	2:30 AM, another resident the staff know the floor. Upon entering the resident lying on the resident's brief was a resident was propping arm. There was blood right side of the resided cleansed the blood fractive bleeding was rebruising and swelling eye. Upon examinating small lens with 2 blue the resident's lower expensed his/her eye, a drainage came from the closure of the eye, the pain. The resident was facility to a hospital was resident was resident was facility to a hospital was resident was re	om the resident's face, noted, and the right eye both above and below on of the resident's eye, extensions was noted eyelid. When the resider a moderate amount of bothe resident's eye and use resident complained of as later transported from the eye for a ruptured glown.	and ne d the t. The d the h one e  no had the , a on nt bloody upon of n the t			
	On 9/4/13 at 3:52 PM, observation revealed the resident propelled himself/herself around the facility in a wheelchair and visited with the staff and other residents.					
	On 9/9/13 at 11:21 AM, Administrative Nurse F stated per the facility's protocol, the staff should have called the physician after the 63/41 blood pressure was obtained.					
	Pulse Parameters po	s 7/8/10 Blood Pressure licy directed the staff to provider if the systolic				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	LE CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED		
17E242				B. WING		09/	09/12/2013	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOSPITAL ONAGA LTCU		206 GR	RESS, CITY, STA AND AVE RYS, KS 665					
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 157	Continued From page 3 pressure is <80 or >190 and the diastolic blood pressure is <40 or >110.  The facility failed to notify Resident #38's physician after a significant change in physical status.			F 157				
	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS			F 279				
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.							
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.							
	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).							
	The facility had a cen sample included 14 re reviewed for accident interview and observa develop a comprehen	not met as evidenced because of 33 residents. The esidents, of which 2 wes. Based on record revation the facility failed to sive plan of care to presampled residents. (#2	ere iew, o event					

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	OVIDER OR SUPPLIER ITY HOSPITAL ONAG	A LTCU	206 GR	RESS, CITY, STA			
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F 279	Continued From page 4			F 279			
	- Review of the medi Resident #29 was ad 6/25/13.	ical record revealed mitted to the facility on					
	Set 3.0 assessment, resident had adequat moderately impaired MDS indicated the re assistance with all (A Living, except eating, resident had unstead	ssion (MDS) Minimum D dated 7/4/13, indicated te vision with glasses ar decision making skills. I sident required total sta DLs) Activities of Daily The MDS indicated the by balance, a history of f Range of Motion in all	the nd The aff				
	The 7/4/13 (CAAs) Care Area Assessment summary for falls indicated the resident had fallen prior to admission, had balance problems and was not able to stand or walk. The summary indicated the resident was transferred per stand up lift and 2 staff assistance and received medications that can cause balance issues and dizziness.						
	The 6/25/13 Fall Risk assessment indicated the resident was at high risk for falls.						
	Review of the resident's 7/9/13 comprehensive care plan revealed no fall care plan to direct the staff for care interventions to prevent falls or further interventions after the resident's falls on 8/16, 8/17, and 8/18/13.						
		PM, nurse's note indicat sident seated on the floo apparent injuries.					
		PM, nurse's note indicatent on the floor in his/her					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM					(X3) DATE SU		
AND PLAN O	- CORRECTION	IDENTIFICATION NUMBE	iK:	A. BOILBING		COMPLETED	
	17E242			B. WING 09/12/20			12/2013
NAME OF PR	IE OF PROVIDER OR SUPPLIER STRE			RESS, CITY, STA	TE, ZIP CODE		
COMMUN	ITY HOSPITAL ONAG	A LTCU		AND AVE			
			ST MAR	RYS, KS 665	536		
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F 279	Continued From page 5			F 279			
	room with no apparer	nt injuries.					
	the staff were with the on the side of the bed use the sit to stand lift. The note indicated the away, the resident state lowered him/her to the On 9/4/13 at 2:43 PM resident, seated in a rarea and staff talking observation revealed socks and had glasse. On 9/5/13 at 2:50 PM resident was able to p	, observation revealed recliner, in the common to him/her. Further the resident wore nones on.  , Nurse Aide G stated to sosition him/herself on the resident was a stated to sosition him/herself on the recliner.	ing ed to it. ift aff the is skid he the				
	side of the bed, but the resident's legs do not support him/her well enough to stand. Nurse Aide G stated the resident sometimes attempted to stand without staff assistance.  On 9/9/13 at 1:50 PM, Nurse A verified the resident had fallen prior to admission to the facility and had fallen 3 times in the facility. He/She verified the facility lacked a care plan to prevent falls for the resident.		t Aide to				
	The facility failed to develop and implement a comprehensive plan of care for Resident #29, who had a history of falls, and had 3 additional falls after admission to the facility.		9,				
	483.25(c) TREATMEI PREVENT/HEAL PRI			F 314			
	resident, the facility m	hensive assessment of nust ensure that a resid without pressure sores ssure sores unless the	ent				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER. AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E242		B. WING		09/	12/2013
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOSPITAL ONAGA LTCU			206 GR	RESS, CITY, STA AND AVE RYS, KS 665	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 314	Continued From page 6 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This Requirement is not met as evidenced by:		F 314				
	This Requirement is not met as evidenced by: The facility had a census of 33 residents. The sample included 14 residents of which 2 were reviewed for pressure ulcers. Based on record review, interview and observation the facility failed to assess pressure ulcers weekly for 2 of 2 sampled residents. (#18, #40)						
	- Resident #18's admission (MDS) Minimum Data Set 3.0 assessment, dated 7/24/13, indicated the resident had intact cognition and was independent with decision making skills. The MDS indicated the resident required extensive staff assistance with toileting and hygiene, limited staff assistance with dressing, and supervision or independent with all other (ADLs) Activities of Daily Living. The MDS indicated the resident was at risk for pressure ulcers, had three Stage 2 (skin open to the 2nd layer) pressure ulcers and interventions included pressure relief devices for the chair and bed, nutrition, ulcer care, dressings and ointments.						
	The 7/25/13 (CAAs) Care Area Assessment summary indicated the resident had three Stage 2 ulcers on admission and he/she was at risk due to a mobility problem and incontinence.  The 7/25/13 care plan directed the staff to provide a regular diet and Prosource (a nutritional supplement), one ounce, twice daily, for wound						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED		
	17E242			B. WING			09/12/2013	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOSPITAL ONAGA LTCU		206 GR	RESS, CITY, STA AND AVE RYS, KS 668					
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Stage 2 dermal up the right great took the staff to encoune every 2 hours or and physician condequate food are protein intake. The staff to provide a document size of observe for signs.  The 7/16/13 Adm Breakdown indicated the resist conditions:  1) 2 open areas (cm) centimeters 2) an open area of 0.25 x 0.25 cm standingsion Skin Ale would assess and weekly.  The Weekly Doctincluded the follo 1) 8/4/13 - 0.3 x after the initial as 2) 8/14/13 - 0.25 (10 days betweet 3) 8/23/13 - 0.3 x (9 days after the 4) 9/6/13 - 0.25 x after the last asset On 9/9/13 at 2:38	e pla e pla licers	n indicated the resident is on his/her buttocks are care plan further direct the resident to reposite often, provide a dietait as needed, encourage uid intake and increase are plan further directed issure reducing mattress pressure ulcers and infection.  On Skin Assessment for the resident was at issure ulcers.  On Skin Assessment to the had the following skin the buttocks measuring 1.5 x 1 cm.  The right great toe measure indicated the strument indicated the strument the open areas intation for the right great intation for the righ	and on exted tion ry exted tion ry exted the standard of the s	F 314				

STATEMENT OF DEFICIENCIES (X*) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
	17E24			B. WING		09/12/2013		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
COMMUN	ITY HOSPITAL ONAG	GA LTCU		AND AVE RYS, KS 665	36			
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F 314	approximately 1 cm diameter open area. Nurse B stated the Prism dressing was in there, with Vaseline gauze over the small open area, 4 x 4 gauze over all and taped on.  On 9/9/13 at 11:15 AM, Nurse B verified the wound record lacked weekly documentation of the resident's pressure ulcers.  The facility's 11/2003 Wound and Skin Protocol for Pressure Ulcers stated if skin breakdown is identified, the staff will provide weekly monitoring, unless otherwise directed by the physician, and contact the physician immediately, when identifying wound and skin problems.  The facility failed to thoroughly assess and document Resident #18's open areas weekly, to monitor healing and/or the need for further interventions.		F 314					
	- Resident #40's admission (MDS) Minimum Data Set 3.0 assessment, dated 7/31/13, indicated the resident had intact cognition. The MDS indicated the resident was independent with most (ADLs) Activities of Daily Living and required supervision with dressing, toileting and hygiene. The MDS indicated the resident was at risk for pressure ulcers and had one Stage 2 skin (open to the 2nd layer) pressure ulcer, which was present on admission. Interventions included a pressure relief device in the chair, ulcer care, dressings and ointments.  The 8/1/13 (CAAs) Care Area Assessment summary indicated the resident had a pressure ulcer, for several months, on his/her left 3rd toe which measured 0.25 x 0.25 (cm) centimeter,		he t with and s at s skin n was d a					

NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOSPITAL ONAGA LTCU  O(A) ID PREFIX TAG  TAG  TAG  TAG  TAG  TO Add in the presence of eschar or slough.  The 8/1/13 care plan directed the staff to provide a regular diet, offer alternatives, high protein snacks between meals and consult the dietician on admission and as needed. The care plan further directed the staff to encourage the resident to reposition every 2 hours or more often, encourage adequate food and fluid intake and increase protein intake.  The 7/24/13 Admission Skin Breakdown Assessment indicated the resident was at moderate risk for skin breakdown. The temporary plan of care on the assessment indicated the staff were to monitor and document the resident's open areas weekly.  The Weekly Documentation included the following measurements of the open area on the residents left foot, 3rd toe:  1) 7/24/13 - 0.25 x 0.25 cm.  2) 8/3/13 - 0.5 x 0.5 cm, no drainage. (10 days after the ulcer was noted on admission)  3) 8/14/13 - 0.5 x 0.5 cm. (11 days after the last assessment)		TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
COMMUNITY HOSPITAL ONAGA LTCU  206 GRAND AVE ST MARYS, KS 66536    CAS   ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE			17E242		B. WING 09/12/20			/2013
(X4) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE DEFICIENCY)  F 314 Continued From page 9 with no presence of eschar or slough.  The 8/1/13 care plan directed the staff to provide a regular diet, offer alternatives, high protein snacks between meals and consult the dietician on admission and as needed. The care plan further directed the staff to encourage the resident to reposition every 2 hours or more often, encourage adequate food and fluid intake and increase protein intake.  The 7/24/13 Admission Skin Breakdown Assessment indicated the resident was at moderate risk for skin breakdown. The temporary plan of care on the assessment indicated the staff were to monitor and document the resident's open areas weekly.  The Weekly Documentation included the following measurements of the open area on the resident's left foot, 3rd toe:  1) 7/24/13 - 0.25 x 0.25 cm, no drainage. (10 days after the uicer was noted on admission)  3) 8/14/13 - 0.5 x 0.5 cm, (11 days after the last assessment)  4) 8/23/13 - no open area. (9 days after the last	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
FREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY    F 314   Continued From page 9   with no presence of eschar or slough.  The 8/1/13 care plan directed the staff to provide a regular diet, offer alternatives, high protein snacks between meals and consult the dietician on admission and as needed. The care plan further directed the staff to encourage the resident to reposition every 2 hours or more often, encourage adequate food and fluid intake and increase protein intake.  The 7/24/13 Admission Skin Breakdown Assessment indicated the resident was at moderate risk for skin breakdown. The temporary plan of care on the assessment indicated the staff were to monitor and document the resident's open areas weekly.  The Weekly Documentation included the following measurements of the open area on the resident's left foot, 3rd toe:  1) 7/24/13 - 0.25 × 0.25 cm, no drainage. (10 days after the ulcer was noted on admission)  3) 8/14/13 - 0.5 x 0.5 cm, (11 days after the last assessment)  4) 8/23/13 - no open area. (9 days after the last	COMMUN	ITY HOSPITAL ONAC	GA LTCU			536		
with no presence of eschar or slough.  The 8/1/13 care plan directed the staff to provide a regular diet, offer alternatives, high protein snacks between meals and consult the dietician on admission and as needed. The care plan further directed the staff to encourage the resident to reposition every 2 hours or more often, encourage adequate food and fluid intake and increase protein intake.  The 7/24/13 Admission Skin Breakdown Assessment indicated the resident was at moderate risk for skin breakdown. The temporary plan of care on the assessment indicated the staff were to monitor and document the resident's open areas weekly.  The Weekly Documentation included the following measurements of the open area on the resident's left foot, 3rd toe:  1) 7/24/13 - 0.25 x 0.25 cm. 2) 8/3/13 - 0.5 x 0.5 cm, no drainage. (10 days after the ulcer was noted on admission) 3) 8/14/13 - 0.5 x 0.5 cm. (11 days after the last assessment) 4) 8/23/13 - no open area. (9 days after the last	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	COMPLETION
On 9/5/13 at 7:45 AM, observation revealed the resident seated on the side of the bed, with no shoes on. Nurse B observed the resident's left 3rd toe, which was not open and had a callous approximately 1 x 1 cm, pink in color.  On 9/9/13 at 2:30 PM, Nurse A verified the staff had not documented the weekly skin assessments for the resident's left 3rd toe, per facility protocol.	F 314	with no presence of a The 8/1/13 care plan a regular diet, offer a snacks between mea on admission and as further directed the sresident to reposition often, encourage ade and increase protein. The 7/24/13 Admissi Assessment indicate moderate risk for skii plan of care on the awere to monitor and open areas weekly. The Weekly Docume following measuremeresident's left foot, 3r 1) 7/24/13 - 0.25 x 0.2 (2) 8/3/13 - 0.5 x 0.5 (3) 8/14/13 - 0.5 x 0.5 (3) 8/14/13 - 0.5 x 0.5 (3) 8/14/13 - no open assessment)  On 9/5/13 at 7:45 AM resident seated on the shoes on. Nurse B of 3rd toe, which was not approximately 1 x 1 of 0 (1) 9/9/13 at 2:30 PM (1) 13 at 2:30 PM (1) 14 and 15 and 15 at 2:30 PM (1) 15 at 2:30 PM (1	directed the staff to produce and consult the dietical needed. The care plantaff to encourage the nevery 2 hours or more equate food and fluid intake.  On Skin Breakdown dight the resident was at not breakdown. The temps sees ment indicated the document the resident's entation included the ents of the open area or red toe:  1.25 cm.  cm, no drainage. (10 do oted on admission)  5 cm. (11 days after the narea. (9 days after the narea. (9 days after the narea. (9 days after the ot open and had a callocm, pink in color.  M. Nurse A verified the staff weekly skin	cian cian cian cian cian cian cian cian	F 314			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE				1 1	CONSTRUCTION	(X3) DATE S COMPL		
		17E242		B. WING		09	09/12/2013	
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F 314	The facility's 11/20 for Pressure Ulcersidentified, the staff unless otherwise dontact the physicidentifying wound at the facility failed to areas weekly, as contact the physicidentifying wound at the facility failed to areas weekly, as contact the physicidentifying wound at the facility failed to areas weekly, as contact the facility failed to areas weekly.	rage 10 103 Wound and Skin Protos stated if skin breakdowr will provide weekly monit lirected by the physician, an immediately, when and skin problems.  10 assess the skin and operare planned for Resident ate risk for skin breakdow	n is coring, and en #40,	F 314				
F 323 SS=D	3 483.25(h) FREE OF ACCIDENT			F 323				
	This Requirement is not met as evidenced In The facility had a census of 33 residents. The sample included 14 residents, of which 2 we reviewed for accidents. Based on record revinterview and observation the facility failed to provide supervision and assistive devices to prevent further falls for 1 of 2 sampled reside (#29)		ne ere view, o					
	Findings included:  - Review of the medical record revealed Resident #29 was admitted to the facility on 6/25/13.  Resident #29's admission (MDS) Minimum Data Set 3.0 assessment, dated 7/4/13, indicated the resident had adequate vision with glasses and							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
AND PLAN O	- CORRECTION	IDENTIFICATION NUMBE	iK:	A. BUILDING		COMPLET	ED
		17E242		B. WING		09/1	2/2013
NAME OF PR	ME OF PROVIDER OR SUPPLIER STREET			RESS, CITY, STA	TE, ZIP CODE	•	
COMMUN	ITY HOSPITAL ONAG	A LTCU		AND AVE	26		
				RYS, KS 665			(VE)
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F 323	Continued From page 11			F 323			
	moderately impaired of MDS indicated the results assistance with all (Al Living, except eating. resident had unsteady and impaired (ROM) extremities.  The 7/4/13 (CAAs) Ca summary for falls indiprior to admission, had was not able to stand indicated the resident up lift and 2 staff assismedications that can	decision making skills. sident required total state DLs) Activities of Daily The MDS indicated the y balance, a history of fange of Motion in all are Area Assessment cated the resident had a balance problems an or walk. The summary was transferred per stated.	e falls fallen d				
	The 6/25/13 Fall Risk assessment indicated the resident was at high risk for falls.						
	Review of the resident's 7/9/13 comprehensive care plan revealed no fall care plan to direct the staff for care interventions to prevent falls or further interventions after the resident's falls on 8/16, 8/17, and 8/18/13.		the				
	The 8/7/13 at 8:00 PM, nurse's note indicated staff found the resident on the floor in his/her room with no apparent injuries.						
	The 8/16/13 at 3:15 PM, nurse's note indicated the staff found the resident seated on the floor in his/her room with no apparent injuries.						
	The 8/18/13 at 8:50 AM, nurse's note indicated the staff were with the resident, who was sitting on the side of the bed, and the staff attempted to use the sit to stand lift to transfer the resident. The note indicated the resident pushed the lift away, the resident started to slide and the staff						

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		17E242		B. WING		09/12/2013		
						09/	12/2013	
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
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			SIMA	RYS, KS 665	)36 			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From page	e 12		F 323				
	lowered him/her to the							
	On 9/4/13 at 2:43 PM, observation revealed the resident, seated in a recliner, in the commons area and staff talking to him/her. Further observation revealed the resident wore non-skid socks and had glasses on.  On 9/5/13 at 2:50 PM, Nurse Aide G stated the resident was able to position him/herself on the side of the bed, but the resident's legs do not		skid the the t					
	side of the bed, but the resident's regs do not support him/her well enough to stand. Nurse Aide G stated the resident sometimes attempted to stand without staff assistance.  On 9/9/13 at 1:50 PM, Nurse A verified the resident had fallen prior to admission to the facility and had fallen 3 times in the facility. He/She verified the facility lacked a care plan to prevent falls for the resident.  The facility failed to implement supervision and assistive devices to prevent further falls for Resident #29, who had a history of falls and experienced 3 additional falls after his/her admission to the facility.		n to					
	329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a		rom s any g ; or quate ose	F 329				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	OVIDER OR SUPPLIER			ESS, CITY, STA	TE, ZIP CODE				
COMMUN	ITY HOSPITAL ONA	GA LTCU		ND AVE YS, KS 665	36				
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F 329	resident, the facility who have not used a given these drugs ur therapy is necessary as diagnosed and do record; and resident drugs receive gradur behavioral interventic contraindicated, in a drugs.	must ensure that resider antipsychotic drugs are raless antipsychotic drug y to treat a specific condocumented in the clinicals who use antipsychotical dose reductions, and ons, unless clinically n effort to discontinue the	not ition I	F 329					
	The facility had a ce sample included 14 reviewed for unnece observation, record facility failed to ensuresident's drug regin unnecessary medication and the first series of the facility failed to ensure resident's drug regin unnecessary medication.  Findings included:  Resident #6's quated Set 3.0 assessment, resident had short a problems, moderate received scheduled antidepressant, and The 8/7/13 care plar administer Seroquel and bedtime.		e e ed on e e ed on e e e ed on e e e e e e e e e e e e e e e e e e						
	the staff to administe	g pnysician's orders direct er Seroquel XR, 100 (mg loon (initiated 3/9/12) an	g)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		. ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
COMMUN	IITY HOSPITAL ONAG	A LTCU		AND AVE RYS, KS 665	36			
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F 329	mg, daily every PM (ii Review of the resident facility's pharmacist of 8/1/12, revealed not gattempt or recomment resident's use of the Stone of the	nitiated 6/11/10).  It's medical record and consultant reviews since radual dosage reduction dation to reduce the Seroquel medication.  M, observation revealed edining room table, early a gradual dear for the resident's eview Resident #6's ion for gradual dosage unal (MDS) Minimum Dadated 8/7/13, indicated bright protime for Merical indicated intact also indicated the residentials indicated the staff to obton the protime (a blood test the takes blood to clot)  Is orders directed the staff to obton the protime (a blood test the takes blood to clot)	of the ting  Floose  ata the ental bed dor, ant, anat	F 329				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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COMMUN	ITY HOSPITAL ONAG	A LTCU		AND AVE	•••			
				RYS, KS 665	536			
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F 329	329 Continued From page 15 monthly.  Review of the resident's medical record revealed the resident did not receive a PT for the months of May and July 2013.  On 9/4/13 at 3:40 PM, observation revealed the resident, seated in a recliner in his/her room, watching television.  On 9/9/13 at 9:19 AM, Administrative Nurse F verified the facility did not obtain a PT from the resident for May or June 2013.			F 329				
	Review of the Medication Monitoring Guidelines policy, dated 6/11/01, directed the staff to obtain a monthly serum pro-thrombin time (PT), unless the physician ordered differently, for residents who received Warfarin and to contact the physician with the results, whether normal or abnormal.		tain a ss the ho an					
	The facility failed to monitor the effectiveness of Resident #12's blood thinner medication.  483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.		s of					
			ORT	F 428				
			d					
	The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.							
		not met as evidenced b sus of 33 residents. Th						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		17E242		B. WING		09/	12/2013	
COMMUNITY HOSPITAL ONAGA LTCU 206		206 GR	RESS, CITY, STA AND AVE RYS, KS 665	,				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	sample included 14 reviewed for unneces observation, record refacility's pharmacist of the director of nursing irregularities for 2 of the 8/3/13 care plan administer Seroquel (and bedtime.  Review of the 8/2/13 the staff to administer milligrams, daily at normal director of the staff to administer milligrams, daily at normal director of the staff to administer milligrams, daily at normal director of the staff to administer milligrams, daily at normal director of the staff to administer of the staff to admin	esidents of which 5 wer sary medications. Base eview and interview, the consultant failed to report, or the physician, drughe 5 sampled resident's erly (MDS) Minimum D dated 8/7/13, indicated d long term memory impaired cognition, and insulin, antipsychotic, diuretic medications. directed the staff to an antipsychotic) at no ephysician's orders directed the staff to an antipsychotic) at no ephysician's orders directed the staff to an antipsychotic) at no ephysician's orders directed the staff to an antipsychotic) at no ephysician's orders directed the staff to an antipsychotic) at no ephysician's orders directed the staff to an antipsychotic) at no ephysician's orders directed the staff to an antipsychotic) at no ephysician's orders directed the staff to an antipsychotic) at no ephysician's orders directed the staff to an antipsychotic) at no ephysician's orders directed the staff to an antipsychotic) at no ephysician's orders directed the staff to an antipsychotic and the staff to an antipsychotic antipsychoti	ed on e et to g st. (#6  ata the d on cted g) d 400 en d the ting	F 428				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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COMMUN	ITY HOSPITAL ONAG	A LTCU		AND AVE				
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F 428	Continued From page	e 17		F 428				
	The facility's pharmacist consultant failed to identify and address the need for a gradual dose reduction of Resident #6's Seroquel, a psychotropic medication.  - Resident #12's annual (MDS) Minimum Data Set 3.0 assessment, dated 8/7/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS also indicated the resident required extensive assistance of 2 staff with bed mobility, transfers, walking in the room/corridor, and received scheduled insulin, antidepressant, anticoagulant, and diuretic medications.  The 8/7/13 care plan directed the staff to obtain a blood laboratory protime (PT) (a blood test that measures how long it takes blood to clot) monthly.  The 8/1/13 physician's orders directed the staff to administer Warfarin (a blood thinner) 3.5 (mg) milligrams, daily, and obtain a (PT/INR) pro-thrombin time monthly.  Review of the resident's medical record revealed the facility did not obtain a (PT) protime for the months of May and July 2013.		dose					
			the ntal ent bed dor,					
	On 9/4/13 at 3:40 PM, observation revealed the resident, seated in a recliner in his/her room, watching television.							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		17E242		B. WING		09/12/2013			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE				
COMMUN	COMMUNITY HOSPITAL ONAGA LTCU 206 GRAND AVE ST MARYS, KS 66536								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION			
F 428	On 9/10/13 at 8:21 A stated the pharmacy the omission of the reprotimes.  Review of the Medica policy, dated 6/11/01 monthly serum pro-th physician ordered diffreceived Warfarin and with the results, whet	me 18  M, Administrative Nurse consultant did not addresident's May and July ation Monitoring Guidelity, directed the staff to obtain time (PT), unless ferently, for residents with the contact the physiciather normal or abnormatist consultant failed to lack of monitoring the dent #12's blood thinned	nes otain a ss the ho an	F 428					